JOHN D. KAUFMAN, M.D.

PATIENT NAME_____ DATE_____

PAST MEDICAL HISTORY (Circle if you have ever had):

Diabetes	Thyroid problems	Emphysema	COPD
Blood clots	Kidney disease	Hernia	Arthritis
Heart attack	Liver disease	Ulcer	Asthma
Heart disease	Jaundice	Hepatitis	High blood pressure
Epilepsy	Skin disease	Anemia	

Cancer (what type?)_____

FAMILY MEDICAL HISTORY (Check which applies)

Blood disease	_____
Heart attack/diseases	_____
Cancer	_____
Diabetes	_____
Tuberculosis	_____
Lung disease	_____
Liver disease	_____
Kidney disease	_____

SOCIAL HISTORY YES NO

Do you smoke cigars/ cigarettes?	___	
If so how many a day?	_____	___
Do you chew tobacco?	___	___
Do you drink alcohol?	___	___
If yes how many glasses/week ?	_____	
Have you ever had excessive bleeding following dental or surgery	____	____
Have you ever taken Cortisone pills?	___	___

Ages of children _____
List any hobbies or recreational activities_____

LIST ALL OPERATIONS & DATES

_____
_____
_____

LIST ALL INJURIES & SERIOUS ILLNESS

_____
_____
_____

REVIEW OF SYSTEMS: (Circle any of these symptoms you have had in the past year)

GENERAL:	Poor appetite or weight change		
HEAD:	Headaches		
EYES:	Blurred or double vision		
THROAT:	Chronic sore throats or difficulty swallowing		
MOUTH:	Loose or false teeth or dental problems		
LUNGS:	Shortness of breath or chronic cough		
HEART:	Chest pain, pounding of the heart or swollen ankles or hands		
ABDOMEN:	Nausea, vomiting, diarrhea, constipation, blood in stools, recurrent indigestion, change in bowel habits or abdominal pain		
GU:	Urinating at night, frequent urination or pain or burning with urination		
HEME:	Easy bruising, difficulty with stopping bleeding		
	Have you ever received a blood transfusion?	Y	N
N/M:	Do you have any numbness or weakness?	Y	N
	If so, where?_____		
	Have you ever had to limit your activities?	Y	N
	If yes please explain_____		

LIST ALL KNOWN DRUG ALLERGIES

_____
_____
_____

LIST ALL MEDICATIONS TAKEN REGULARLY

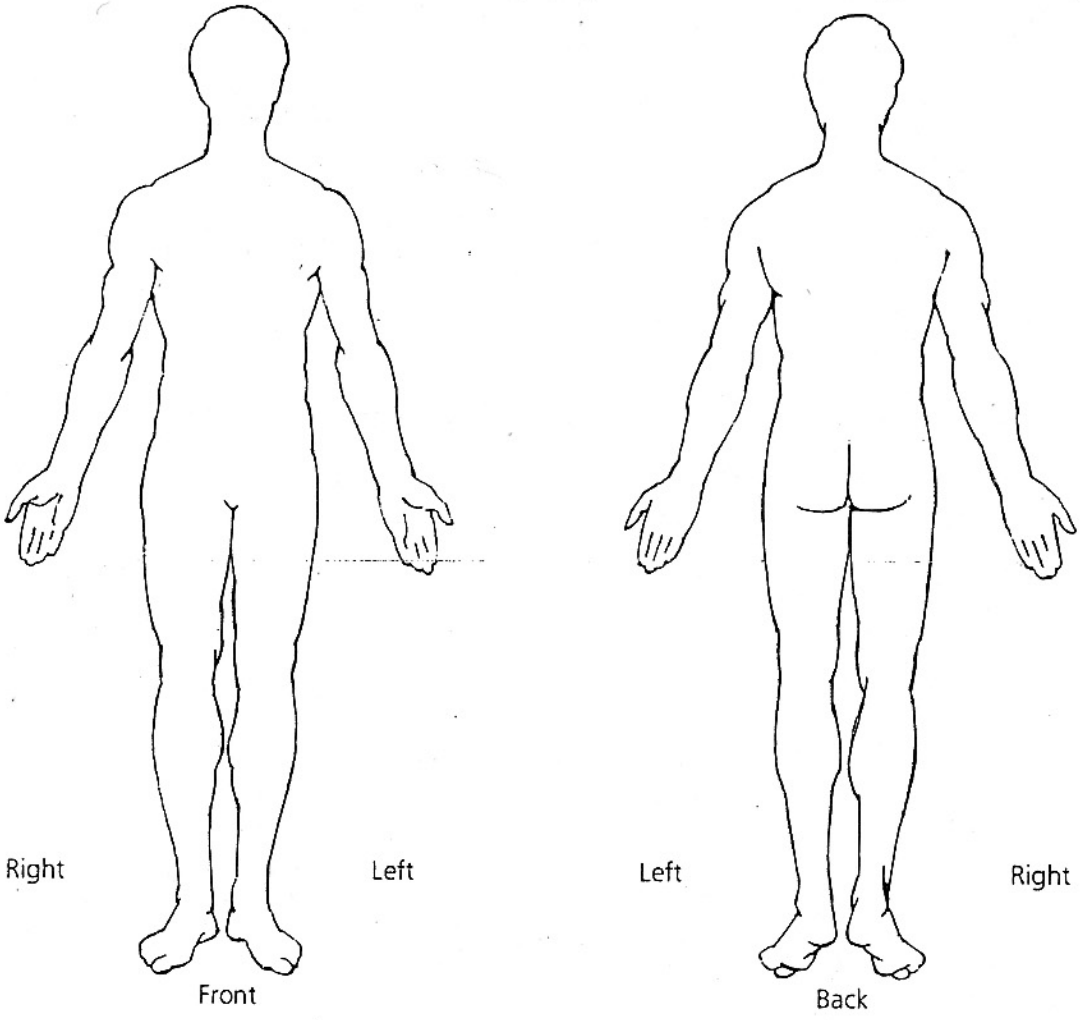
_____
_____
_____

Name _____ Date _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below, using the appropriate symbol. Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching ▲ ▲ ▲ Numbness = = = Pins and needles ○ ○ ○ Burning × × × Stabbing / / /



How bad is your pain now?

Please mark with an X on the body form where the pain is worst now.

Please mark on the line how bad your pain is now:

No pain _____ Worst possible pain

When (roughly what date) did you present pain start? _____

How long have you had this pain? _____

How long have you had similar pain? _____

How did the pain start? (check the appropriate box)

- ! Suddenly
- ! Gradually
- ! Lifting
- ! Twisting
- ! Fall
- ! Injured at work
- ! Injured in auto accident
- ! Hit from behind
- ! Inured during sports
- ! No apparent cause

What activities make the pain worse? (check the appropriate box)

- ! Exercise
- ! Sitting
- ! Standing
- ! Walking
- ! Bending
- ! Coughing

What reduces the pain? (check the appropriate box)

- ! Lying down
- ! Sitting
- ! Standing
- ! Exercises in physical therapy
- ! Pain pills
- ! Nothing
- ! Other _____